The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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Medical Review Team
Application for Certification for Short Term Stay
In a Pediatric Skilled Nursing Facility

Thank you for your request for an application for a short-term stay in a pediatric nursing facility. All required forms are enclosed.

Each section of the application must be completed with current complete information. Incomplete application packets will be returned.

Once a completed application is received, the case will be scheduled for review by designated members of the Medical Review Team (MRT) The MRT meeting will be scheduled within a week of the date on which the application is received. If long term residential care is subsequently requested, an updated case review will then be conducted by all MRT members to determine if the child meets the long term care criteria.

Please mail applications to:

Dr. Katja Gerhardt, MPH
Medical Review Team Coordinator
Mass. Dept. of Public Health
Division for Children & Youth with Special Health Needs
250 Washington Street
5th Floor
Boston, MA 02108
Email: Katja.gerhardt@mass.gov

APPLICATION FOR SHORT TERM STAY
IN A PEDIATRIC SKILLED NURSING FACILITY

APPLICATION PACKET

This MRT application packet must be completed and submitted in its entirety. The full packet will be used to establish eligibility for short-term care in a pediatric nursing facility. Incomplete packets will be returned.

APPLICATION PACKET CHECKLIST

____Parent/Guardian Consent Form

____Reason for seeking short term stay

____Anticipated length of stay

____Application for Short Term care

____Comprehensive Medical Summary and supporting documents

____Comprehensive Social Summary

____Comprehensive Developmental/Functional Summary stating a developmental age

____IFSP for individuals younger than 3 years of age

____IEP for individuals 3 years of age or older

Child's Name Date

FOR INTERNAL USE:

Date initially Received_____ Date complete Packet Received_____

Date of MRT Review_____

MRT Decision: ____Certified ____Deferred _____Not Certified

Date of Notification of Decision_____

MEDICAL REVIEW TEAM
PARENT/GUARDIAN CONSENT FORM
FOR SHORT TERM STAY IN A
PEDIATRIC NURSING FACILITY

I understand that the attached application constitutes a request for my child to stay in a Massachusetts pediatric nursing home for a period not to exceed 90 days in a year. I also understand that the Medical Review Team (MRT), convened by the Massachusetts Department of Public Health, is mandated to certify an individual's eligibility for short term nursing home placement for individuals under twenty-two (22) years of age.

I consent to have the MRT obtain and review my child's medical, social, developmental and educational records. I understand that all information received by the MRT will be kept confidential. I further understand that the MRT packet will be forwarded only to those facilities or professionals who will be involved in determining my child's eligibility for a pediatric nursing home.

I have read and understand the above information and consent to the review of information on my child. I also understand that findings of the MRT will be in effect for one year from the date of review and that updated information on my child will need to be submitted and reviewed again if nursing home admission is sought beyond the certification dates. If placement beyond 90 days per year is requested, I understand that this will require review by the full Medical Review Team.

Child's Name (print) Date of Birth

Parent/Guardian's Signature Date

Referral Source Name (print) Date

Referral Source Signature

APPLICATION FOR A SHORT TERM STAY
IN A PEDIATRIC SKILLED NURSING FACILITY

Massachusetts Department of Public Health
Bureau of Family Health and Nutrition
Division for Children and Youth with Special Health Needs

MRT DATA REQUIREMENTS:
Each portion of this form **must** be completed

REASON FOR APPLICATION:_____

IDENTIFYING DATA:

1. Child's Name:_____
2. Child's Birth Date___/___/___ Sex: ___ M ___F
3. Child's Health Insurance_____
   If Masshealth, does the child have Kaleigh Mulligan? Yes No Don't know
4. Parent(s) or Primary Caregiver(s) Name(s), Address and Phone number:

   _____

   _____

   _____

   Telephone_____ Cell Phone: _____

   Email_____
5. Diagnosis: _____

   _____
6. Referred by:

   Name: _____

   Title/Position: _____

   Hospital/Agency_____

   Address: _____

   Telephone: _____ Email:_____

7. MDPH Race, Ethnicity, and Language-Preference

Introduction: In order to guarantee that all clients receive the highest quality of care and to ensure the best services possible, we are collecting data on race and ethnicity. Could you please select the category or categories that best describes your background?

7a. Is the applicant Hispanic/Latinx? Latinx is a gender-neutral term to refer to a Latino/Latina person

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

7b. What is the applicant's ethnicity? (You can specify one or more). Ethnicity represents the applicant's ethnic origin or descent, heritage, or nationality or the place of birth of the applicant or their ancestors.

7c. What is the applicant's race? (You can specify one or more)

- ☐ American Indian/Alaska Native (specify tribal nation_____)
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian or Other Pacific Islander (specify_____)
- ☐ White
- ☐ Other (specify_____)
- ☐ Do not know
- ☐ Prefer not to answer

7d. What language does the applicant/parent/legal guardian prefer to communicate in about health? (You can specify one or more)

- ☐ Albanian
- ☐ American Sign language
- ☐ Amharic, Somali, or other Afro-Asiatic
- ☐ Arabic
- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (specify dialect_____)
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Khmer
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Swahili or other Eastern or Southern African
- ☐ Vietnamese
- ☐ Yoruba, Twi, Igbo, or other Western African
- ☐ Other (specify_____)

7e. In what language does the applicant/legal guardian/parent prefer health-related written materials? (You can specify one or more)

- ☐ Albanian
- ☐ Amharic, Somali, or other Afro-Asiatic
- ☐ Arabic
- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (specify dialect_____)
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Italian
- ☐ Khmer
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Swahili or other Eastern or Southern African
- ☐ Vietnamese
- ☐ Yoruba, Twi, Igbo, or other Western African
- ☐ Other (specify_____)
- ☐ Large print
- ☐ Braille
- ☐ Needs assistance reading written material

MEDICAL CARE:

A medical summary provided by a primary care, specialty or attending physician written within the last 2 months must be included.

***The summary must include the information described in the OUTLINE attached to this packet. Please use the other side of the page when additional space is needed**.

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Physicians' Names	Specialty	Frequency of visits	Location	Date of last visit

NURSING PROCEDURES/TREATMENTS:

If your child receives **nursing services** please include the last monthly summary. Indicate the relevant frequency of the following procedures.

1. Respiratory/cardiac care
   No special procedure_____
   Ventilator_____
   Tracheostomy_____
   Requires O2_____Date of last use: _____Provide O2 Log: _____
   Chest physical therapy/ postural drainage _____
   Deep Upper Airway Suctioning _____
   Monitors (Specify)_____
   Other monitoring equipment_____

2. Feeding Programs
   No specific program_____
   Hyperalimentation (IV feedings) _____
   Difficult oral feedings_____
   Gavage/tube (G, G-J, NG)_____
   Specialized diet_____
   Special positioning/equipment: (describe:) _____
   Other_____

3. Bowel and Bladder Care
   Bladder catheterization: indwelling or intermittent_____
   Suppositories/enemas_____
   Ostomy care_____
   Other (list) _____

4. Other Nursing Procedures and Skilled Assessments
   VP shunt _____
   Seizure Disorder: _____
   Frequency: _____Date of last seizure: _____Provide seizure log: _____
   Seizure intervention _____Date: _____
   Special skin care including ostomy and wound site care _____
   Turning/positioning _____
   Other _____

5. Medications: (List all medications, dosage, administration techniques)
   _____
   _____
   _____
   No medications_____

ATTENTION: IF PRN IS INDICATED ON ANY LINE, PLEASE LIST DATE LAST GIVEN OR PERFORMED _____

DEVELOPMENTAL/FUNCTIONAL STATUS:

In addition to this checklist, a **comprehensive developmental/functional summary,** based on an evaluation performed within the year, must be included. The summary must include the information described in the outline attached to this packet.

1. Cognitive Function (Check highest level)
   - No delay _____
   - Slight/mild delay _____
   - Severe delay _____
   - Profound delay _____
   - Unable to assess _____

2. Behavioral/Social (Check all that apply)
   - No difficulties _____
   - Does not interact with others _____
   - Acts out against self _____
   - Acts out against others _____
   - Sleep Difficulties _____
   - Self-stimulatory behavior _____
   - Hyperactivity _____
   - Other (Describe)

3. Communication (Check highest level)

Expressive

___Communication is age appropriate
___Speaks in sentences
___Speaks phrases/words
___Some sounds with meaning
___Communicates non-verbally
___Sign language
___Communication Board
___Computer
___Other (describe)
___Some sounds without meaning
___No communication
___Unable to assess

Receptive

___Understanding is appropriate for age
___Understands language readily
___Limited understanding
___Responds to verbal cue
___No response
___Unable to assess

4. Self Care Skills (Check highest level

Independent/Age Needs Totally

	Appropriate	Assistance	Dependent
a. Feeding	_____	_____	_____
b. Dressing	_____	_____	_____
c. Personal Hygiene (teeth, hands, face)	_____	_____	_____
d. Bathing	_____	_____	_____
e. Toileting (Indicate highest level)	_____	_____	_____

Bladder
___Complete independent
___Time voiding
___ Little/no control
___Catheter/bag

Bowel
___Completely Independent
___ Needs some assistance
___ Little/no control
___ Bag

4. Arm/Hand Use (Indicate the highest level)

Right: ___full use ___partial use ___little/no control ___no use
Left: ___full use ___partial use ___little/no control ___no use

Please indicate hand dominance/preference or that both hands are used equally well.

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5. Mobility/Locomotion (Check all that apply)

___Appropriate for age
___Ambulates
___Ambulates w/assistance
___Ambulates w/assertive device
___Independent in wheel chair
___Needs assistance in wheelchair
___Independent in transfers
___Needs assistance with transfers
___Sits independently
___Sits with assistance
___Stands independently
___Stands with assistance
___Rolls over
___Totally dependent

6. Equipment use

Indicate all necessary equipment with (R) Rented or (O) owned

___No special equipment
___Wheelchair (power/manual)
___Walker/crutches/cane
___Hearing aids
___Glasses/contact lens
___Dressing aids
___ Seating system other than wheelchair
___Braces/casts/special shoes
___Communication devices
___Other (describe)

7. Therapy Services

SERVICES	FREQUENCY	LOCATION

Educational Programming

A detailed summary of any applicable educational program (through an early intervention report (IFSP), Individualized Education Plan (IEP) or a Ch. 688 Transition Plan (ITP) must be included in the application packet. These summaries should include the name of the program or school in which the child is enrolled, a contact person and their name and telephone number.

If the child is not participating in an educational program please explain

Has the school system made any arrangements for providing educational services to the child during the short-term stay?

SUPPORT SERVICES
(frequency = hrs/day/week) (Funding Source = DDS, DMH, DCF, MCB, DMA or other)

SERVICES	FREQUENCY	FUNDING SOURCE
Nursing Services		
Personal Care Attendant Services		
Home Health Aide		
Out-of-Home Respite		
Counseling		
Case Management		
Day Care		
Recreation/after school program		
Other (list)		

Outline for Comprehensive Medical Summary

Children referred for MRT review usually have had medical summaries prepared in conjunction with comprehensive medical evaluations in a hospital or clinic. If the summary was written in the past 2 months and includes the data listed below, a new summary need not be prepared. If a current summary does not exist it needs to be secured and submitted by the child's primary medical care provider.

A summary **MUST** include the following:

1. Presenting problem(s)/diagnosis(es)
2. Prenatal, perinatal, and neonatal history
3. Health history including a complete description, by diagnoses or organ system involvement, of active or previously active problems. Include date of onset, Results of evaluation, functional implications and prognosis or date of resolution. Neurologic, musculo/skeletal and nutritional/feeding issues should be addressed.

More specifically, the health history will include:

- Growth and physical development (including growth parameters)
- Medications: schedule, dose, route of administration
- Allergies
- Immunizations
- Hospitalizations/surgical procedures: please include discharge summaries from hospitalizations that have occurred during the last year
  - Significant trauma history
  - Nutritional status
  - Respiratory history and status
  - Bowel/bladder status
  - Skin condition
  - Cognitive/behavioral/developmental status

4. Psychiatric History: Please list DSM-IV diagnosis

5. Family Medical History: Special attention needs to be given to genetic issues and any additional special medical needs.

6. Physical Examination Report

7. Visual and hearing assessment/testing reports. When applicable please indicate if registered with the Massachusetts Commission for the Blind

8. Conclusion: summarizing diagnoses, etiology and prognosis and listing specific recommendations

Outline for Comprehensive Social Summary

The social summary should be prepared by a social service professional who knows the child and his/her family and has visited the home. The summary should be prepared in consultation with the family, and include the following information:

1. Reason for referral for short term stay at a pediatric nursing home.

2. Anticipated length of stay.

3. Primary language spoken at home and access to interpreter services

4. Description of all community services, resources and/or state agencies which are providing services or support to the child and his/her family. Include names of caseworkers involved. Also include other services and supports which may be helpful to the child and his/her family but are currently unavailable.

5. Description of the current relationship of the child and his/her family with the referral source. Include frequency and quality of contact, and plans for follow up.

6. Summary and recommendations for child's current and future care based on family's intermediate and long range goals. Summarize the reasons for requesting short term residential care at this time.

Outline for Comprehensive Developmental/Functional Summary

Children referred for MRT review have usually had developmental summaries prepared either in conjunction with comprehensive medical evaluations or educational plan evaluations. If the developmental summary was written in the past year and includes the data listed below, a new summary need not be prepared. **This summary should be prepared by the child's developmental pediatrician, educational or developmental specialist and/or occupational, physical, speech/language therapists.**

The summary must include the following:

1. Description of developmental milestones achieved in the areas of cognition, gross/fine motor, self-help, social and expressive/receptive language skills.

2. Summary of most recent developmental evaluation, including progress reports, names of standardized tools for assessment, and focusing on gross/fine motor, expressive/receptive language skills, visual processing and visual/motor integration.

3. Description of all equipment used to enhance functioning and independence: communication boards, seating systems, adaptive utensils, etc..

4. Overview of **functional status and approximate developmental age**, including capacity for self-care, mobility, communication and verbal/visual comprehension, cognition, emotional/behavioral status. Please conclude with a statement of goals and recommendations for treatment.